**Oral Health Risk Factors**

**Patient’s Name:**

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1. **Do you smoke or have you EVER smoked?**
   - [ ] Yes
   - [ ] No

   (If No, proceed to question 2)

   **The amount that you are presently smoking**

   - [ ] None (quit smoking completely)
   - [ ] Less than 1 pack of cigarettes per day
   - [ ] An occasional cigarette
   - [ ] 1-2 Packs of cigarettes per day
   - [ ] A few cigarettes per day
   - [ ] 2 or more packs of cigarettes per day
   - [ ] An occasional cigar
   - [ ] Cigars on a daily / regular basis
   - [ ] A pipe on a daily / regular basis

   If you have quit smoking, when did you quit?

   - [ ] Less than 6 months ago
   - [ ] 6 months to a year ago
   - [ ] 1 to 3 years ago
   - [ ] Over 3 years ago

   **How many years have you or did you smoke?**

   - [ ] Less than 2 years
   - [ ] 2-5 years
   - [ ] 5-10 years
   - [ ] 10-20 years
   - [ ] Over 20 years

2. **Do you / Have you EVER chew/chewed tobacco or use/used snuff or other similar substance?**
   - [ ] Yes
   - [ ] No

   (If No, proceed to question 3)

   **Are you STILL using smokeless tobacco or snuff?**

   - [ ] Yes
   - [ ] No

   If No, **WHEN did you quit?**

   - [ ] Less than 6 months ago
   - [ ] 6 months to a year ago
   - [ ] 1 to 3 years ago
   - [ ] Over 3 years ago

   **How many years did you use or have you used smokeless tobacco?**

   - [ ] Less than 1 year
   - [ ] 1-2 years
   - [ ] 2-5 years
   - [ ] Over 5 years

3. **Approximate average amount of alcoholic beverages presently consumed per week:**

   - [ ] None
   - [ ] Less than 1 per week
   - [ ] 1-5 drinks
   - [ ] 6-11 drinks
   - [ ] 11-20 drinks
   - [ ] Over 20 drinks

4. **Do you have or have you ever had a substance abuse problem?**
   - [ ] Yes
   - [ ] No

   **Describe**

5. **Do you presently use any recreational drugs?**
   - [ ] Yes
   - [ ] No

6. **Do you have or have you ever had an eating disorder?**
   - [ ] Yes
   - [ ] No

   **If Yes, Please Specify:**

7. **Do you have or have you ever had any head, neck or mouth piercing(s)? (Other than ears)**
   - [ ] Yes
   - [ ] No

   **List**

8. **Do you have or have you ever been informed that you have been infected with an oncogenic strain (possible cancer-causing) of the Human Papilloma Virus (HPV)?**
   - [ ] Yes
   - [ ] No

9. **Please list your history or any family member’s history of cancer:**

10. **Other concerns and considerations:**

CONSENT—To the best of my knowledge, all of the preceding information is correct and if there is ever any change in health, or medications, this practice will be informed of the changes without fail. I also consent to allow this practice to contact any healthcare provider(s) and to have the patient’s health information released to aid in care and treatment. I also hereby consent to allow diagnosis, proper health care and treatment to be performed by this practice for the above named individual until further notice. I understand there are no guarantees or warranties in health or dental care.

**Signature**

**Date**

**(Parent or guardian, if patient is a minor)**

**Reviewed By:**